Challenge TB - Afghanistan
Year 2
Quarterly Monitoring Report
October-December 2015

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Cover photo: A health care worker is conducting triage for signs and symptoms of TB among patients at Bamyan provincial hospital (Photographer: Delaqa Safi, CTB staff)

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Abbreviations

ACF	Active case findings
AFB	Acid Fast Bacili
AFG-T-MOPH	Afghanistan tuberculosis fund from global fund
BHCs	Basic health centers
BPHS	Basic package of health services
BRAC	Bangladeshi rural advancement committee
CB-DOTS	Community based DOTS
CCM	Country coordination mechanism
CHW	Community health worker
CI	Confidence interval
CI	Contact investigation
CTB	Challenge TB
DOT	Direct observed treatment
DOTS	Direct observed treatment short course
ERR	Electronic recording and reporting
GF	Global Fund
HCW	Health care worker
HIV	Human immune deficiency virus
ICF	Intensified case finding
IDPs	Internally displaced persons
INH	Isoniazid
IPT	Isoniazid preventive therapy
KNCB	Netherland's Tuberculosis organization
MDR	Multi-drug resistance
MOPH	Ministry of public health
MSH	Management Sciences for Health
NGO	Non-governmental organizations
NTP	National Tuberculosis Program
OR	Odds ratio
OR	Operations research

PHO	Provincial health office
PMDT	Programmatic management of drug resistant tuberculosis
PMU	Program management unit
PP	Private practitioner
PR	Principle recipient
QRW	Quarterly review workshop
SEHAT	System enhancing for health actions in transition
SOP	Standard operation procedure
SR	Sub-recipient
STTA	Short term technical assistance
TB	Tuberculosis
TB CAP	Tuberculosis control assistance program
TB CARE I	USAID funded tuberculosis project
TBD	To be determined
TBIC	Tuberculosis infection control
TBIS	Tuberculosis information system
UNDP	United nations development program
USAID	United States Agency for International Development
USD	United states dollar
VCCT	Voluntary confidential counselling and testing
WHO	World Health Organization

1. Quarterly Overview

Country	Afghanistan
Lead Partner	MSH
Other partners	KNCV
Work plan timeframe	October 2015 – September 2016
Reporting period	October - December 2015

Most Significant Achievements

The major priorities for CTB Afghanistan during year two are:
1) DOTS expansion to densely populated area. CTB assisted the NTP with the expansion of DOTS implementation to densely populated urban areas in the cities of Kabul, Herat, Kandahar, Jalalabad and Mazar.
2) DOTS expansion to remote and hard to reach area. The community based DOTS was extended and maintained to 14 out of 15 provinces through sub-contracts with basic package of health services (BPHS) implementing organizations.
3) Providing safer health care settings for health care workers, clients and communities. During the first year of the Challenge TB project, TBIC activities were implemented in 196 health facilities. During the first quarter of Year 2, TBIC activities were implemented in an additional 10 health facilities.
4) Increasing health care staff capacity. During this reporting period, 279 (237 male, 42 female) public and private health care staff from five provinces of Bakh, Herat, Kandahar, Nangerhar and Kabul who were initially trained on DOTS, were given (refresher or initial trainings.

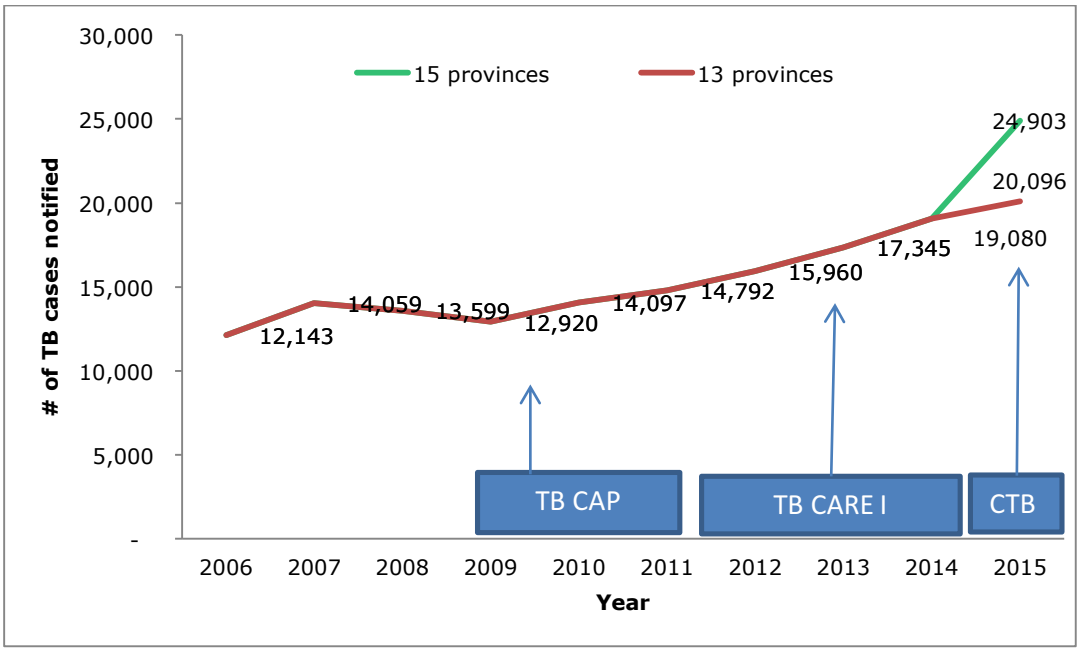
In comparison to last quarter, all of CTB Afghanistan's activities contributed to building the capacity of the NTP, NGOs and frontline health care staff to maintain a 10% increase in presumptive TB patient identification, a 9% increase in bacteriologically confirmed pulmonary TB and a 15% increase in all forms of TB case notification. Moreover, between quarter three of 2014 and 2015, the TB case notification for new bacteriologically confirmed TB cases and all forms TB cases was 78 and 186 respectively per 100,000 population, demonstrating a 56% improvement compared to national case notification of 119 per 100,000 population (See Table 1). During the third quarter of 2015, the NTP was supported to identify 40,561 individuals with presumptive TB which led to the diagnosis of 6,845 (2,946 male, 3,899 female) of all forms of TB and the diagnosis of 2,882 (2,941 male, 3,899 female) with new bacteriologically confirmed pulmonary TB cases in CTB intervention areas in 15 provinces (See Table 5).

Table 1: Comparison of TB case notification in CTB intervention provinces, Quarter 3 2014 - Quarter 3 2015

Variable	**2014 (Q3)**	**2015 (Q3)**	Difference (%)
presumptive TB	36,743	40,561	10
Bacteriologically confirmed TB	2,634	2,882	9
All forms of TB cases	5,966	6,845	15
Case notification in 100,000 pop	162.34	186.26	15

Additionally, CTB is building on the successes from the previously USAID funded TB projects, TB CAP and TB CARE I, and sustained an increase in TB case notification through 2009-2015 and maintained higher TB case notification annually, from 13,599 in 2009 to almost 25,000 in 2015 (See Figure 1).

Figure 1: Trend of TB case notification in CTB Intervention Areas, 2006-2015



Furthermore, contact investigation was strengthened and expanded to new cities covered by urban DOTS which led to a 30% increase in contact screening, a 39% increase in contacts tested for TB and a 21% increase in all forms of TB case notification this quarter, in comparison to the previous quarter (See Table 2). During this quarter, the NTP and BPHS implementers were also supported in the identification and symptomatic screening of 10,834 (5,459 male, 5,375 female) individuals in close contact to index (bacteriologically confirmed pulmonary TB) TB cases. Of those screened, 1,852 (887 male, 965 female) were identified with presumptive TB (cough for more than two weeks) and were tested for pulmonary TB. As a result, 159 people (83 male, 76 female) (See Table 5) were diagnosed with all forms of TB and 97 (36 male, 61 female) were diagnosed as bacteriologically confirmed pulmonary TB cases. The TB case notification for all forms of TB among contacts of bacteriologically confirmed TB cases in Afghanistan is 1,468 in per 100,000 contacts to index TB cases. Based on these results, CTB can conclude that the yield of TB among household contacts of TB cases is 7.9 times higher than the WHO estimated incidence for the general population of Afghanistan (OR of 7.9, confidence interval of 6.4-9.7 and p value of <0.0000001).

CTB Contribution to TB among Children

Challenge TB has enhanced detection, diagnosis and treatment amongst children. For instance, there was a 28% increase in household contacts registered and screened for TB and a 55% raise in household contacts tested for TB, and a 31% improvement in child identification as contacts to index TB cases and a 46% increase in number of children put on IPT (Table 2). The total number of children identified as contacts were 5,586 in 2014 and 7,309 in 2015, also in 2014 3,767 children were put on IPT and this number was 5,518 in 2015 (Table 2). Moreover, during Quarter 3 (2015), 1,986 (1,003 male, 983 female) children under the age of five were estimated to be in close contact to index TB cases. Of them, 1,846 (92%) (934 male, 912 female) children were identified as contacts with index cases and 1,440 were put on Isoniazid Preventive Therapy (IPT).

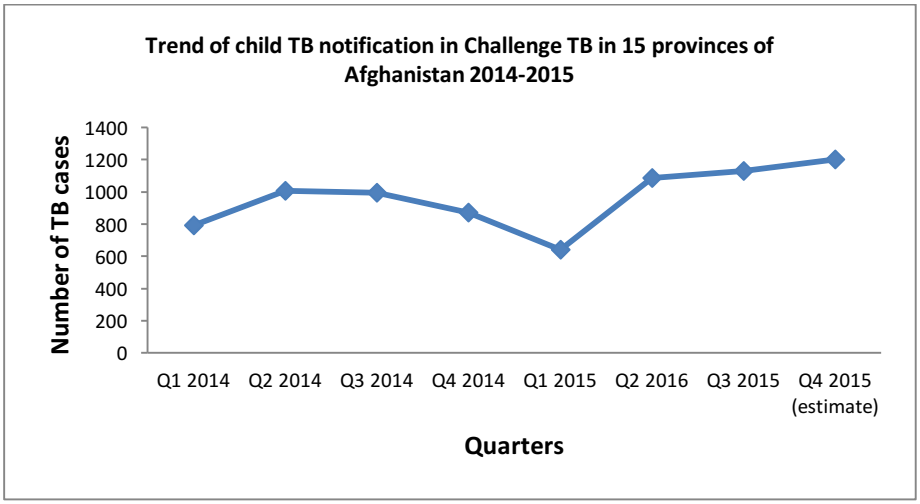
Table 2: Trend of contact investigation and childhood TB in CTB areas (15 provinces) in Afghanistan 2014-2015

Variable	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Total 2014	Q1 2015	Q2 2015	Q3 2015	Q4 2015 (estimate)	Total 2015	Difference (%) 2014-2015
House hold contacts registered	8,035	8,920	8,363	7,903	33,221	9,336	10,404	10,834	12000	42574	**28**
Household contacts screened for TB	1,231	1,165	1,331	1,097	4,824	1,848	1,801	1,852	2000	7501	**55**
All forms TB cases	119	119	131	109	478	161	204	159	185	709	**48**

Bacteriologically confirmed TB cases	72	78	73	79	302	100	86	97	120	403	**33**
Estimated no. children under the age of five in contacts with index cases	1,533	1,725	2,945	1,589	7,792	1,490	2,136	1,986	2300	7912	**2**
Children under the age of 5 identified as contacts to index cases	1,272	1,409	1,455	1,450	5,586	1,349	1,914	1,846	2200	7309	**31**
Children under the age of 5 who were started on IPT	969	774	1,058	966	3,767	1,019	1,559	1,440	1500	5518	**46**

In addition, during this quarter, TB diagnosis among children was strengthened which resulted in a 11% improvement in TB case notification among children for all forms of TB cases and a 6% increase in new bacteriologically confirmed TB cases (See Figure 2). For example in 2014, 3,665 TB cases were diagnosed among children and this number increased to 4,060 in 2015. The sudden fall in TB case notification among children is caused by the closure of the STOP TB project called TB REACH that provided assistance to a children's hospital in Kabul. CTB closed this gap through alternative and more sustainable approaches for example by integrating TB services into the expanded immunization program in Khost provincial hospital, Kandahar Mirwais hospital, Nangerhar TB center and in the four district hospitals of Nangerhar province. In Khost provincial hospital alone, 168 children under the age of 15 were diagnosed with TB. These diagnoses make up 44% of all TB cases (382) diagnosed by this hospital during first three quarters of 2015. Despite these many diagnoses in 2015, the Khost provincial hospital did not report any child TB cases in 2014.

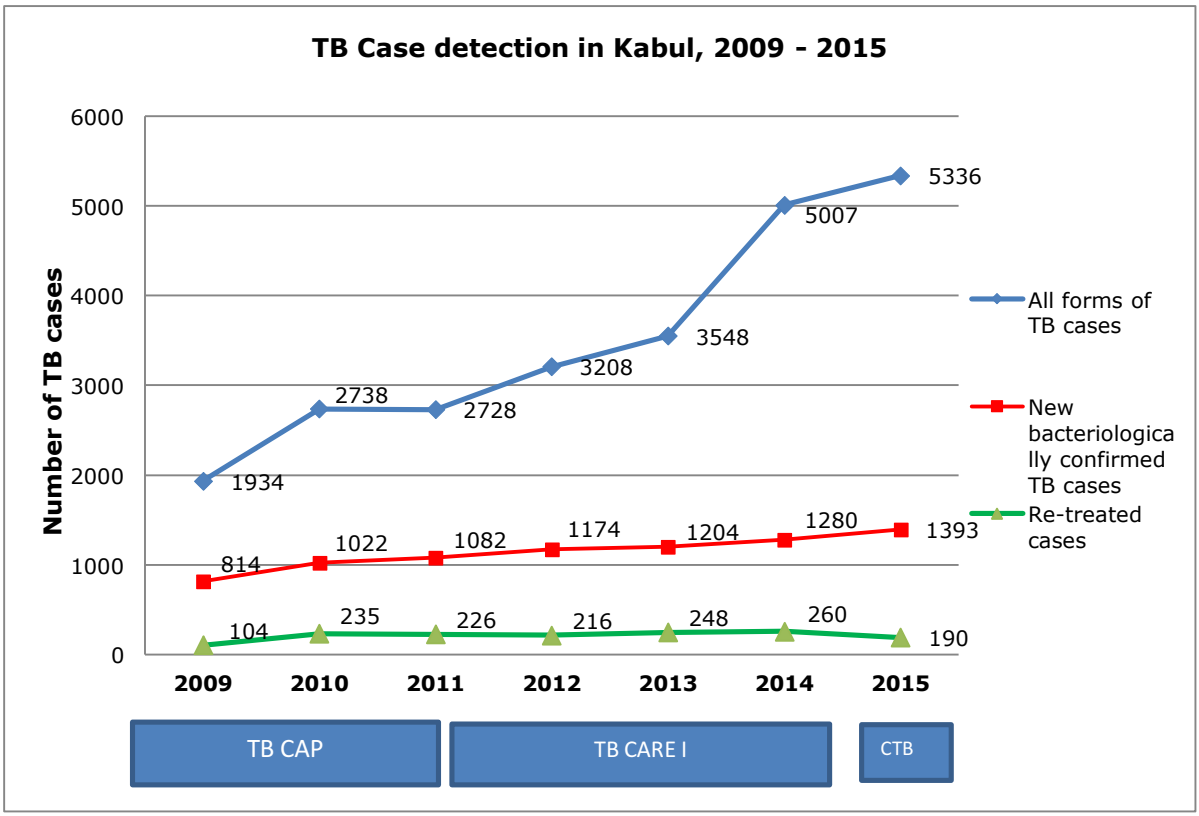
Figure 2: The trend of child TB case notification in Afghanistan



Urban DOTS Implementation

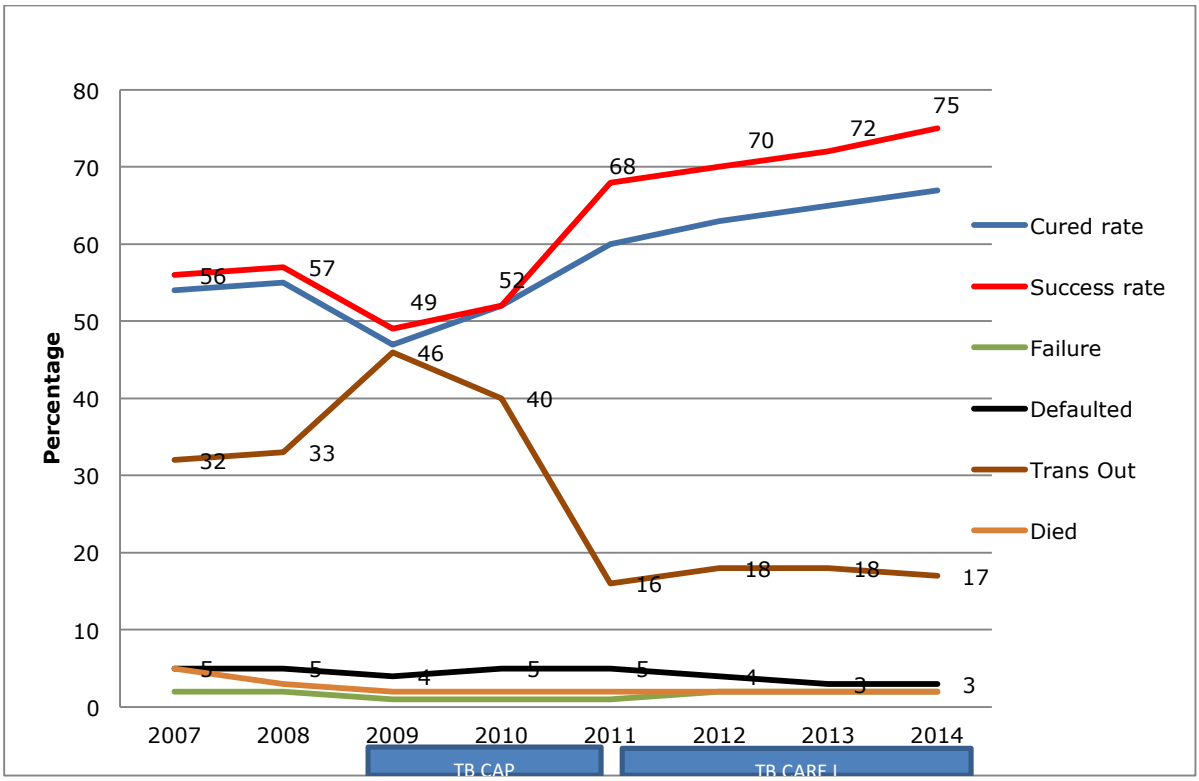
During the first quarter of year two, CTB expanded DOTS to additional public and private health facilities in the five cities of Herat, Kabul, Kandahar, Jalalabad and Mazar-i-Sharif. In total, 10 new public and private health facilities engaged in Urban DOTS (2 public, 1 prison and 7 private hospitals). Additionally, 131 health care staff (lab technicians, nurses and doctors) of the five cities, were trained on the standard operating procedure for case detection/diagnosis, treatment, TB infection control, contact investigation and laboratory diagnosis of Acid Fast Bacili (AFB). And, Urban DOTS also built on results produced during the TB CAP and TB CARE I projects. For example, TB case notification in Kabul for all forms of TB increased by 6.5% from 5,007 in 2014 to 5,336 in 2015 - a huge jump from only 1,834 cases in 2009. New bacteriologically confirmed TB cases improved by 9% from 2014 to 2015 (and by 71% from 2009) (See Figure 3).

Figure 3: Trend of TB case notification in Kabul, 2009-2015



Furthermore, urban DOTS implementation resulted in improved TB treatment outcomes in Kabul and in the rest of the urban cities. The treatment outcomes of the four cities that were covered by urban DOTS during this quarter will be reported in the next quarter. The treatment success rate improved by 2% in 2014 and reached 75% (See Figure 4). One of the continued challenges for Kabul urban-DOTS is the higher transfer rate of 17%. CTB has strived to address this challenge by creating strategies to minimize transferring and improve the cure and treatment success rates. Some of the strategies include engaging in active follow-up of TB patients who initiated their treatment in Kabul and continue treatment in their local provinces and strengthening the referral system between health facilities to report the treatment outcomes of patients who transfer to other locations.

Figure 4: Treatment outcome of urban DOTS in Kabul, 2007-2014



The Urban DOTS expansion to three additional cities (Kandahar, Herat and Jalalabad) resulted in significant achievements. For example, from 2014 to 2015 there was a 93% and a 53% increase in new bacteriologically confirmed TB cases and all forms of TB cases respectively in these three cities. The total number of new bacteriologically confirmed TB cases notified across these three cities in 2014 was 187 which increased to 362 in 2015. Additionally, the number of all forms of TB cases notified in 2014 was 669, which increased to 1,021 in 2015 (See Table 3).

Table 3: Results of Urban DOTS Implementation in the newly covered cities of Jalalabad, Kandahar and Herat, 2015

Provinces	Kandahar		Jalalabad		Herat		Total		Difference 2014-2015
	2014	2015	2014	2015	2014	2015	2014	2015	
Outpatient attendance over 15Y	NA	59,993	NA	31,201	NA	40,988	NA	132,182	NA
Presumptive TB cases	NA	1,752	NA	1,409	NA	2,130	NA	5,291	NA
Bacteriologically confirmed pulmonary TB cases	62	121	74	138	51	103	187	362	93%
All forms TB Cases	166	405	357	365	146	251	669	1,021	53%

During quarter 1, an active contact screening strategy was introduced in the cities of Herat, Kandahar and Jalalabad and health care workers began the activities related to the strategy. As a result, active contact screening was conducted for the facilities of 800 index TB cases and INH preventive therapy was initiated for children under the age of 5 (See Table 3). In Kabul, 1,698 household contacts of index TB cases were screened for the signs and symptoms of pulmonary TB. Of those screened, 187 people (98 male, 89 female) (11%) were identified with presumptive TB. They were then tested for pulmonary TB and 8 (4%) (6 male, 2 female) were diagnosed with bacteriologically confirmed pulmonary TB. During 2015, the household contacts of 1,186 (77%) index TB cases were evaluated for signs and symptoms of TB. Of those evaluated, 6,040

individuals were registered as contacts to index TB cases and 645 (11%) were identified with presumptive pulmonary TB and were then tested for TB. Of the 645 who were tested, 53 (8%) were diagnosed as having all forms of TB. Thus, the TB case notification among household contacts in Kabul city is 877 per 100,000 contact population and the yield of TB among household contacts in the city of Kabul is 4.5 times higher than the WHO estimation of TB incidence among the general population (OR of 4.7, CI of 3.4-6.3, p-value of <0.000001).

In addition, 250 (138 male, 112 female) children under the age of 5 were identified as having contact with the index TB cases. The children were screened for signs and symptoms of TB and 230 (92%) were put on IPT and 97 (42%) completed their IPT.

In summary, the Urban DOTS implementation in Kabul, Herat, Kandahar and Jalalabad resulted in the identification and examination of 8,791 individuals with presumptive TB, the detection of 712 bacteriologically confirmed pulmonary TB cases and 1,961 cases with all forms TB. In addition, as a result of DOTS expansion to three prisons, 50 all form TB cases were identified. Following DOTS expansion to the private health sector, 320 all form TB cases were diagnosed.

Community Based DOTS (CB-DOTS) Implementation

The implementation of Community Based DOTS in rural and hard to reach areas of 14 provinces was possible through contracts with eight local BPHS implementing NGOs. During this quarter, CTB assisted the NTP to expand CB-DOTS to 14 provinces through sub-contracts with BPHS implementing NGOs. The sub-contracts were initially delayed by 6 months due to the prolonged administrative contract process. The CB-DOTS contracts with NGOs were signed mid-October 2015 and during this quarter the NGOs were only expected to complete the administrative process staff recruitment and training of health care staffs and community health workers. As a result, CTB Afghanistan has less outcome data to present the performances of CB-DOTS this quarter.

In total, 593 leaders of health facilities were oriented on the CB-DOTS scope of work and on the recording and reporting of overall TB and CB-DOTS outcome performances. Additionally, 547 community health supervisors and 11,348 community health workers (CHWs) were trained on TB and CB-DOTS approaches. The CB-DOTS implementers were assisted by CTB and the NTP to conduct community awareness events. As a result, 163 community awareness events were conducted in all 14 provinces. Additionally, 140 billboards with TB messages were installed in communities and radio messages were broadcasted through local radios in 14 provinces (See Annex I).

Moreover, 131 supervisory visits were conducted by CB-DOTS technical officers of implementing NGOs at health post levels. CTB provided assistance to community health workers to implement CB-DOTS effectively and efficiently. CB-DOTS implementation was evaluated, feedback was provided and action plans were developed to address the gaps at the health facility level.

In addition, the 27 best performing health workers including CHWs, community members, laboratory technicians, nurses and doctors were rewarded with in kind gifts such as stoves (paid by CTB). Criteria for selection were number of presumptive TB patients' referrals and identification and number of TB cases notified. There was also a CTB initiative that established a cured TB patients association in 15 provinces with the goal of reducing stigma, promoting community assistance, awareness and trust and encouraging TB patients to adhere to their treatment. Collectively, 54 cured TB patients associations were established and started their collaboration with health facilities by referring presumptive TB cases and providing treatment for confirmed TB patients.

In Quarter 1, CTB-DOTS implementation also resulted in covering of 223 basic health centers (BHCs) and in the identification of 4,335 presumptive TB patients who were referred for diagnosis to health facilities. Of those referred, 200 (4.6%) were diagnosed with bacteriologically confirmed pulmonary TB (See Table 5). Community health workers are providing daily treatment to 260 TB patients in their villages.

Tuberculosis Infection Control

Between October and December 2015, 10 health facilities were assessed for TB infection control (TBIC), their re-design was planned and TBIC committees were established. Furthermore, CTB assisted the NTP in conducting on-the-job training for 150 health care staff from Kabul, Nangarhar and Kandahar to assist frontline health care staffs with implementing TBIC measures and with standard implementation. During the training, health care staff went to DOTS excellence centers to assess the structural design of high-risk areas, patient flow, case-finding processes as well as recording and reporting with the intention of copying best practices. Moreover, a TBIC pocket guide was developed and translated into local languages. Three thousand copies of the pocket guide will be printed and distributed to health facilities countrywide.

The implementation of TBIC was assessed to measure a number of time intervals at 19 purposively selected health facilities in 8 provinces –the time between a presumptive TB case's arrival and departure from the health facility, as well as time from sputum collection until diagnosis and the time to treatment initiation. Collectively, the assessment team selected 94 individuals (42 intervention cases, 52 control cases) available and present at the time of the assessment for interviews at both intervention and control facilities. The team used a questionnaire, documented patient arrival time, identification of presumptive TB cases, documented sputum collection, diagnosis and treatment initiation. The assessment revealed that it took 45 minutes for a person with presumptive TB from his/her identification until his/her departure from the health facility at intervention facilities and 58 minutes for the same process to occur at control facilities. Additionally, in intervention facilities, sputum collection took 28 minutes, AFB smear microscopy took 30 minutes and reporting smear microscopy results by laboratory to DOTs nurse, patient diagnosis and treatment initiation took 54 hours (see table 4). In control facilities, the time between identification of a patient with presumptive TB took 58 minutes time and the time until their departure, took 178 minutes. Additionally, sputum collection took 73 minutes, smear microscopy for AFB took 75.6 minutes, and the reporting of results by the laboratory to DOTS clinicians took 77 minutes. The clinician's sharing of results with the patient took 78 minutes and lastly, the entire process from diagnosis until initiation of treatment took 79 hours (see table 4).

Table 4: Results of TBIC assessment

Variable	Intervention facilities	Control facilities	Remarks
Time from arrival till identification as presumptive TB	45 minutes	58 minutes	
Time spend on sputum collection	28 minutes	73 minutes	
Time spend on AFB microscopy	30 minutes	75.6 minutes	
Results reported to patients	54 minutes	77 minutes	
Time from arrival till departure	54 hours	79 hours	

M&E, Surveillance and Research

The CTB team from Afghanistan and the NTP/MOPH team presented four abstracts and one symposium on contact investigation at the 46th world conference on lung health and TB. This conference was held in Cape Town, South Africa from 2nd to 6th December, 2015.

CTB assisted the NTP with completing a report on an assessment exploring the magnitude of pulmonary TB among diabetes in Afghanistan. This assessment was conducted between October and December 2014 and the report was completed this quarter. In total, 990 (265 male and 725 female) diabetic patients were enrolled in the study, 144 (14.6%) Type I and 846 (85.4%) Type II diabetes patients. The mean age of the patients was 49.61, the mean body mass index (BMI) was 28.58 and the mean glycemic level was 159.68 milligrams/deciliter. Collectively, 113 (11.4%) study subjects were identified as presumptive to have pulmonary tuberculosis disease. Their sputum smear was collected and X-rays were taken. The sputum smear microscopy examination discovered two (1.8%) bacteriologically confirmed pulmonary TB cases. Furthermore, the X-rays showed three patients (2.7%) as clinically confirmed TB cases while two diabetic patients were already undergoing TB treatment. In brief, this assessment demonstrated that TB case notification among patients with diabetes was 202 for new bacteriologically confirmed cases (odds ratio of 2.5 in a 100,000 person population) and 707 for clinically confirmed TB cases (odds ratio of 3.7 in a 100,000 person population). Based on the results of the assessment, the incidence and prevalence of TB among diabetes is 9 times higher than case notification among the general population and 4 times higher than the WHO estimated incidence and prevalence of TB. Thus, we strongly recommend the engagement of diabetic centers in TB as well as the screening of TB patients for diabetes.

Technical/Administrative Challenges and Actions to Overcome Them

The delayed vetting process of subcontracts resulted in the late implementation of CB-DOTS. MRCA, the NGO for Paktiya province still has not received vetting clearance. To address this issue, CTB worked jointly with NGOs and completed the vetting process forms that saved time and strived to shorten process. Furthermore, the CTB team prepared the work plan for the NGOs which was submitted to the home office and PMU earlier and resulted in a 10 month extension of contracts with all of the NGOs.

The expansion of urban DOTS to Mazar-i- Sharif city and the introduction of active contact screening in Herat, Kandahar and Nangahar provinces has been delayed owing to late approval of work plan for year two. The communication with the provincial team was strengthened and the position was re-posted so as to find qualified candidates. The recruitment process is in its last stage.

CTB has been challenged by the low capacity of health care workers on the planning for TBIC measures as well as its implementation and monitoring. The structural design and construction of health facilities where airborne infection control precautions are critical, have not been considered. CTB AFG continues to advocate for the MoPH to consider airborne infection precautions in the design phase of new health facilities.

2. Year 2 Activity Progress

Sub-objective 1. Enabling environment								
Planned Key Activities for the Current Year	Activity #	Planned Milestones				Milestone status	Milestone met? (Met, partially, not met)	Remarks *(reason for not meeting milestone, actions to address challenges, etc.)*
		Oct-Dec 2015	Jan-Mar 2016	Apr-Jun 2016	Year end	Oct-Dec 2015		
To sign subcontracts for CB-DOTS implementation with 9 NGOs in 15 provinces	1.1.1	9 NGOs/15 provinces	9 NGOs/15 provinces	9 NGOs/15 provinces	9 NGOs/15 provinces	8 NGOs/14 provinces	Partially met	One subcontract (Paktyia, MRCA) is still waiting for USAID vetting unit clearance
To conduct CB-DOTS taskforce meeting	1.4.1	45 meetings in 15 provinces	45 meetings in 15 provinces	45 meetings in 15 provinces	45 meetings in 15 provinces	30 meetings in 14 provinces	Partially met	The implementation period of CB-DOTS with NGOs was two months in this quarter, in addition one province still does not have a contract with an NGO
To conduct visits and monitoring to health facilities to monitor the implementation of CB-DOTS	1.4.2	7 visits to 7 provinces and visit 4 health facilities and two health posts in each visits	7 visits to 7 provinces and visit 4 health facilities and two health posts in each visits	7 visits to 7 provinces and visit 4 health facilities and two health posts in each visits	7 visits to 7 provinces and visit 4 health facilities and two health posts in each visits	7 visits to 7 provinces and visit 4 health facilities and two health posts in each visits	Met	
To conduct an annual coordination workshop	1.4.3		One event with 55 participants				N/A	Planned for Quarter 2

Sub-objective 3. Patient-centered care and treatment								
Planned Key Activities for the Current Year	Activity #	Planned Milestones				Milestone status	Milestone met? (Met, partially, not met)	Remarks *(reason for not meeting milestone, actions to address challenges, etc.)*
		Oct-Dec 2015	Jan-Mar 2016	Apr-Jun 2016	Year end	Oct-Dec 2015		
To conduct a strengthening coordination workshop between the public and private health sectors in five cities, Kabul, Mazar, Herat, Kandahar and Jalalabad cities 60 individuals from different stakeholders in each city To engage private practitioners (PP) in TB services in five cities, 20 PPs in each province and in total, 100 PPs will engage in TB services in Kabul, Mazar, Herat, Kandahar and Jalalabad cities To install two digital X-ray machines in urban-DOTS cities	**3.1.1**	Workshop for 75 participants Two digital X-ray machine procured (procurement report)	Workshop for 75 participants Training for 50 participants	Workshop for 75 participants Training for 50 participants	Workshop for 75 participants	Strengthening coordination workshop between public – private health sectors conducted in Kabul for more than 70 representatives The purchase order for two digital X-ray machines are in pipeline and the room setups for two other machine that purchased during first year are under process	Partially met	Strengthening coordination workshop between public and private health sectors for the other four cities is planned for Quarter 2 Planned for Quarters 2 and 3 The procurement of two digital X-rays is in process and will be completed next quarter
and To conduct an assessment of 30 new public and private health facilities in Kabul, Mazar, Herat, Kandahar and Jalalabad cities To expand TB services to 30 public and private health facilities in these five cities	**3.1.2**	8 health facilities assisted TB services expand to 8 health facilities	8 health facilities assisted TB services expand to 8 health facilities	8 health facilities assisted TB services expand to 8 health facilities	6 health facilities assisted TB services expand to 6 health facilities	Assessment of 8 private health facilities completed DOTS expanded to 10 new public and private HFs	Met	
Initial and refresher training for health care staff	**3.1.3**	Training for 110 health care staffs	Training for 110 health care staffs	Training for 110 health care staffs	Training for 110 health care staffs	SOPs training conducted for 131 health care workers in 5 urban DOTS cities	Met	

To establish 5 technical panel reviews of specialists in each city to support the identification of TB in children, complicated and extra pulmonary TB cases in Kabul, Mazar, Herat, Kandahar and Jalalabad) STTA to develop SOPs for diagnosis and treatment of extra pulmonary TB cases	**3.1.4**	1 technical panel STTA report and draft SOPs	1 technical panel	1 technical panel	1 technical panel	Two technical panels review established in Kabul	Partially met	The establishment of technical panel review will take place after the finalization of extra pulmonary TB SOPs The STTA has been rescheduled for Q2 owing to delay in obtaining visa
To conduct TB awareness campaigns for 4,000 students and community members in Kabul, Mazar, Herat, Kandahar and Jalalabad cities Broadcasting TB messages by local radios and TVs	**3.1.5**	800 individuals attended awareness events 15 TB messages aired by local media	800 individuals attended awareness events 15 TB messages aired by local media	800 individuals attended awareness events 15 TB messages aired by local media	800 individuals attended awareness events 15 TB messages aired by local media	6 awareness TB events conducted in 4 cities and more than 1,221 individuals attended TB messages broadcasted by local media	Met	
To support the laboratory network system in 5 urban DOTS cities by providing microscope spare parts	**3.2.1**	Spare parts for 14 microscopes	Spare parts for 12 microscopes	Spare parts for 12 microscopes	Spare parts for 12 microscopes		Not met	This activity has been rescheduled for the upcoming quarters. CTB assisted NTP to complete the assessment in Q1 and repair will take place in next quarters
To establish a monthly provincial task force meeting in selected cities (12 TB taskforce meetings will be conducted in each city) To conduct coordination meetings with different stakeholders in five urban DOTs cities	**3.2.2**	15 taskforce meetings 15 coordination meetings in 5 cities	15 taskforce meetings 15 coordination meetings in 5 cities	15 taskforce meetings 15 coordination meetings in 5 cities	15 taskforce meetings 15 coordination meetings in 5 cities	12 taskforce meetings conducted during the quarter in 4 cities 36 coordination meeting conducted in 5 cities (Kabul, Herat, Mazar, Kandahar and Jalalabad)	Partially met	The recruitment of a local consultant for Mazar has been delayed owing to local authority concurrence in the recruitment process.

To conduct orientation workshops for health care workers and health volunteers in Herat, Mazar, Kandahar and Jalalabad	**3.2.3**	170 volunteers attended events	170 volunteers attended events	170 volunteers attended events	170 volunteers attended events	The first batch of orientations will be conducted for 200 volunteers of Herat ARCS in January 2016	Partially met	The activity has been rescheduled to next quarter and coordination has started with the local ARCS. This activity completed was in three cities and will be complete in two other cities next quarter.
To conduct quarterly review (QRW) meetings for urban-DOTS HFs (private HFs and NGO HFs) who are not covered by GF budget during the 4 quarters of the year, and in total, 20 QRW in five cities, Kabul, Mazar, Herat, Kandahar and Jalalabad cities To conduct a 1 day quarterly review workshop for 40 private practitioners and referral centers in Kabul city	**3.3.3**	200 HCW attended in five cities	200 HCW attended in five cities	200 HCW attended in five cities	200 HCW attended in five cities	Quarterly review meeting conducted in 5 cities implementing urban DOTS and more than 334 health workers participated	Partially met	Quarterly review for referral HFs will start in Quarter 2
To conduct 200 supervisory visits to 140 health facilities by quarter in the 5 cities of Kabul, Mazar, Herat, Kandahar and Jalalabad cities.	**3.3.3**	50 visits in all five cities conducted	50 visits in all five cities conducted	50 visits in all five cities conducted	50 visits in all five cities conducted	77 visits conducted from health facilities in 5 cities and 153 HFs covered	Met	
To conduct active contact investigation of 4,000 index TB patients in 5 urban cities	**3.3.3**	1,000 index cases screened	1,000 index cases screened	1,000 index cases screened	1,000 index cases screened	800 index TB cases screened in 4 cities of Mazar, Jalalabad, Herat and Kandahar	Partially met	
1. To establish a standardized recording and reporting system in urban health facilities, 126 public and private HFs will reporting to NTP quarterly base- NTP data collection formats	**3.2.5**	126 health facilities reporting TB data	126 health facilities reporting TB data	126 health facilities reporting TB data	126 health facilities reporting TB data	Reports submitted from 126 HFs (86 health care workers trained on recording and reporting system in Kabul)	Met	
To engage two additional children specialized hospitals in the management of TB in	**3.1.1**		2 hospitals engaged				Partially met	The assessment of Two children's hospitals has been completed

children (Child SOPs training for three days/60 health care workers + 10 facilitators) 2.To engage two new diabetic centers in TB services in Kabul and Mazar-i- Sharif to screen diabetic patients for active TB and strengthen the referral system 3. To conduct a 15 day-long STTA on assessing TB and diabetes situation analysis and developing TB and diabetes SOPs for case detection and treatment		STTA report and draft SOP		Two diabetic centers engaged in TB		One additional diabetic center engaged in the TB program in Kabul		and two digital X-ray machines will be installed in the hospitals The STTA for TB/diabetes is under negotiation with NTP and planned for next quarter.
To conduct active case finding in IDP camps and TB among diabetes	**3.1.2**	5 IDPs camps screened for TB	5 IDPs camps screened for TB	5 IDPs camps screened for TB	5 IDPs camps screened for TB	Assessment in camps to do situation analysis were carried out	Partially met	This activity will be conducted jointly with the GF/UNDP and the GF has not started the activity
To conduct orientation session for VCCT staff in five cities	**3.1.1**		2 batches of training for 20 participants	2 batches of training for 20 participants	2 batches of training for 10 participants			

Sub-objective 5. Infection control								
Planned Key Activities for the Current Year	Activity #	Planned Milestones				Milestone status	Milestone met? (Met, partially, not met)	Remarks *(reason for not meeting milestone, actions to address challenges, etc.)*
		Oct-Dec 2015	Jan-Mar 2016	Apr-Jun 2016	Year end	Oct-Dec 2015		
1. Assist the NTP to select 30 health facilities for TB IC expansion and implementation in 15 CTB provinces	5.1.1	10 facilities assessed	10 facilities assessed	10 facilities assessed	30 total facilities assessed	10 facilities assessed in districts of Jalalabad, Goshta, Khogiani, Kama, Kandahar, Spinboldak, Zherai, Kabul, Charasiab and Qarabagh	Met	Selection criteria: that facilities with higher risk of infection and workload such as district and provincial hospitals and some CHCs, easily

2. Assist the NTP to establish TB IC committee in assessed 30 health facilities	5.1.2	10 TBIC committees established 75 meetings conducted	10 TBIC committees established 75 meetings conducted	10 TBIC committees established 75 meetings conducted	75 meetings conducted Total conducted during the year: 300	10 TBIC committees established 75 meetings conducted by the TBIC committees at health facilities. The members are health care staff. The committees reviewed the planned activities and intend to implement TBIC measures to identify presumptive TB cases and diagnose it as quickly as possible. Only in Kandahar, it resulted in 23% increase in TB case notifications this quarter compared to same quarter of 2014.	Met	ToR TBIC committees: develop and implement TB infection control measures, conduct regular committee meetings and monitor the implementation of TBIC
3. To develop TB infection prevention and laboratory biosafety Job Aid (Pocket Guide for professional health care providers)	5.1.3		3,000 copies of pocket guide developed and disseminated				N/A	
4. To conduct training on airborne precaution standards (which will be incorporated into the design of any construction/ renovation) and to conduct on-the-job training on TBIC control strategies	5.1.4	50 staff attended the orientation sessions 100 HCW attended on the job training	50 staff attended the orientation sessions 100 HCW attended on the job training		100 attendees 200 HCWs	50 staff attended the orientation sessions 100 HCW attended on the job training.	Met	The staff trained through this training are health care staff from TBIC committees
5. Assist the NTP to consider airborne precaution measures in health facilities' high-risk areas and to assist the NTP to redesign and install mechanical ventilation equipment in the laboratories in 15 provinces	5.1.5	10 assessments conducted 10 health facilities renovated from	10 assessments conducted 10 health facilities renovated from	10 assessments conducted 10 health facilities renovated from	30 assessments 30 facilities redesigned	10 health facilities assessments were conducted and TA (local) was provided to BPHS/SEHAT to renovate health facilities	Met	Under the year two, CTB provides technical assistance to private sector to redesign health facilities for TBIC only in urban DOTS facilities in five provinces

		SEHAT/BPHS project	SEHAT/BPHS project	SEHAT/BPHS project				
Redesign health facilities for TB infection control	5.2.1	10 health facilities renovated from SEHAT/BPHS project	10 health facilities renovated from SEHAT/BPHS project	10 health facilities renovated from SEHAT/BPHS project	30 renovations	10 health facilities not renovated	Not met	TA provided to BPHS to re-design, renovate health facilities according to the assessment findings but they did not complete this renovation due to lack of budget in BPHS work plan. CTB will discuss this with MOPH.
Conduct surveillance of TB among HCWs	5.2.2		600 HCW assessed for active TB				N/A	CTB started the protocol development and completed literature review

Sub-objective 7. Political commitment and leadership								
Planned Key Activities for the Current Year	Activity #	Planned Milestones				Milestone status	Milestone met? (Met, partially, not met)	Remarks *(reason for not meeting milestone, actions to address challenges, etc.)*
		Oct-Dec 2015	Jan-Mar 2016	Apr-Jun 2016	Year end	Oct-Dec 2015		
To coordinate the CB-DOTSs activities with BPHS implementing NGOs to gain their commitment to DOTS	7.2.1	One event per quarter	One event per quarter	One event per quarter	One event per quarter	One event conducted in Kabul December 2015. In total 16 individuals from NTP, CTB and NGOs participated. The CB-DOTS implementation was reviewed and feedback provided	Met	
Cost sharing by private sector	7.2.3		10 health facilities supplied with equipment	10 health facilities supplied with equipment	10 health facilities supplied with equipment		N/A	
Cost sharing by private sector	7.2.4	Provision of TB services for each month for one year	Provision of TB services each month for a year	Provision of TB services each month for a year	Provision of TB services each month for a year	37 private health facilities covered by urban DOTS. Each health facility dedicated one room for DOTS. The cost of each room is estimated at $100 per month. The total estimated cost share will be $3,700	Met	

Cost sharing by PHO and NGO	7.2.5	15	15	15	15 (totally 60 visits supported)	The PHO of Nangerhar, Herat and Kandahar provided an office for CTB consultants. This quarter it was 3*3 months (9 months total) that was provided by PHOs. The estimated cost of the office is 9*$200=USD $1800	Partially met	
Support the NTP to conduct the annual national evaluation workshop	7.3.1			100 participants attended this event			N/A	
Workshop on political commitment to DOTS	7.3.2		25 participants	30 participants	55 participants in a year		N/A	
Cost sharing by private sector	7.3.3		cost share tool applied at 20 health facility	Cost sharing tool applied at 10 health facility			N/A	
NTP leadership competency	7.3.4	15 staff from NTP attended/applied core function tool	20 staff from NTP attended/applied core function tool	20 staff from NTP attended/applied core function tool		The NTP core functions tool was developed	Partially met	NTP core functions tool will be applied beginning of Q2

Sub-objective 10. Quality data, surveillance and M&E								
Planned Key Activities for the Current Year	Activity #	Planned Milestones				Milestone status	Milestone met? (Met, partially, not met)	Remarks *(reason for not meeting milestone, actions to address challenges, etc.)*
		Oct-Dec 2015	Jan-Mar 2016	Apr-Jun 2016	Year end	Oct-Dec 2015		
TB electronic reporting system (TBIS)	10.1.1		Revised database				N/A	
TBIS training	10.1.2		60 staff trained	60 staff trained	120 staff trained		N/A	

Monitor electronic reporting	10.1.3	16 visits	16 visit	16 visits	16 visits (64 visits)	4	Partially met	This quarter, the NTP conducted remote assistance to provinces to monitor the TBIS implementation. During Q2, the team will visit the provinces with poor performance. Q1 focus was on feedback provision and revision of NTP guidelines incl. reporting formats.
TB data quality assessment	10.1.4			Assessment protocol and final report			N/A	
To support quarterly review workshops and supervision to heath facilities	10.1.5	15 quarterly review workshops held	15 quarterly review workshops held	15 quarterly review workshops held	15 quarterly review workshops held	15 quarterly review workshops held	Met	

3. Challenge TB's Support to Global Fund Implementation in Year 2

Current Global Fund TB Grants

Name of grant & principal recipient *(i.e., TB NFM - MoH)*	**Average Rating***	**Current Rating**	**Total Approved Amount**	**Total Disbursed to Date**	**Total expensed** *(if available)*
AFG-T-UNDP	B1	B1	$ 11 million	$ 4.6 million	N/A
AFG-T-MOPH	NA	NA	$ 2.2 million	$ 0.5 million	N/A

In-country Global Fund status - key updates, current conditions, challenges and bottlenecks

The principle recipient (PR), UNDP and the MoPH began implementing the activities for 6 months through a subcontract with sub-recipient Bangladeshi Rural Advancement Committee (BRAC). While the subcontract ended in the middle of December 2015, UNDP extended the contract for an additional month. The PR purchased 4 GeneXpert machines that were handed over to the NTP to install in four regional reference hospitals. Other procurements are in the pipeline, a feasibility assessment for the renovation of MDR wards has been initiated, quarterly provincial and national review workshops were conducted and central and provincial NTP staff received their salaries through the AFG-T-MOPH grant. Despite these accomplishments, there were challenges hindering the smooth implementation owing to lengthy government (approval) processes that resulted in delayed implementation of various aspects of Quarter 1 activities. Negotiations with local organizations to select SRs for activity implementation are in process. Furthermore UNDP decided not to contract BRAC the sub-recipient, and is going to implement the activity on its own. Since UNDP has fewer staff they may be challenged by the need to reach all 34 provinces.

Challenge TB & the Global Fund - Challenge TB Involvement in GF Support/Implementation, any Actions Taken During this Reporting Period

The MSH/CTB project director as a member of the country coordination mechanism (CCM), assisted UNDP and MoPH/NTP in the SR selection process and in communicating between the PR, SR, GF and the MOPH/NTP. CTB coordinated with the PR, SR, the NTP and the MOPH through a TB taskforce and the CCM to ensure that planned activities are implemented as per schedule and to propose an amendment to the implementation plan. For example, CTB assisted the NTP in the selection process of the SR and the implementation of GF activities such as conducting provincial and national quarterly review workshops. Furthermore, the implementation of activities was facilitated through five biweekly TB task force meetings.

4. Success Stories – Planning and Development

Planned success story title:	Private hospitals aligned to treat TB patients in Kabul city, Afghanistan
Sub-objective of story	3. Patient-centered care and treatment
Intervention area of story:	1.4. Provider side: Patient centered approach integrated into routine TB services for all care providers for a supportive environment
Brief description of story idea:	A private hospital's nurse is proud to contribute to the treatment of TB patients
Status update: The success story is ready and is attached to this report	

5. Quarterly Reporting on Key Mandatory Indicators

Table 5.1 MDR-TB cases detected and initiating second line treatment in country (national data)

Quarter	Number of MDR-TB cases detected	Number of MDR-TB cases put on treatment	Comments:
Total 2010	19	0	
Total 2011	22	22	
Total 2012	38	38	
Total 2013	49	48	
Total 2014	90	90	
Jan-Mar 2015	14	13	
Apr-Jun 2015	22	22	
Jul-Sep 2015	18	18	
Oct-Dec 2015	26	26	
Total 2015	80	79	

Table 5. 2 Number and percent of cases notified by setting (i.e. private sector, prisons, etc.) and/or population (i.e. gender, children, miners, urban slums, etc.) and/or case finding approach (CI/ACF/ICF)

		Reporting period					Comments
		Oct-Dec 2015	Jan-Mar 2016	Apr-Jun 2016	Jul-Sept 2016	Cumulative Year 2	
Overall CTB geographic areas	TB cases (all forms) notified per CTB geographic area *(List each CTB area below - i.e. Province name)*						
	Kabul	1,327					
	Kandahar	637					
	Herat	800					
	Nangerhar	1,004					
	Bamyan	134					
	Ghazni	325					
	Khost	392					
	Paktia	223					
	Paktika	198					
	Badakhshan	228					
	Takhar	333					
	Baghlan	378					
	Balkh	420					
	Faryab	217					
	Jowzjan	229					
	TB cases (all forms) notified for all CTB areas	6,845					
	All TB cases (all forms) notified nationwide (denominator)	9,388					
	% of national cases notified in CTB geographic areas	75%					
Intervention (setting/population/approach)							
Community referral	CTB geographic focus for this intervention	14 provinces (all provinces listed above except Paktyia					The sub-contract with 1 NGO has been delayed, thus, CB-DOTS has not been implemented in Paktyia
	TB cases (all forms) notified from this intervention	200					
	All TB cases notified in this CTB area (denominator)	6,622					
	% of cases notified from this intervention	3%					

Contact investigations	CTB geographic focus for this intervention	15 provinces					
	TB cases (all forms) notified from this intervention	159					
	All TB cases notified in this CTB area (denominator)	6,845					
	% of cases notified from this intervention	2%					
Reported by private providers (i.e. non-governmental facilities)	CTB geographic focus for this intervention	5 cities					Jalalabad, Herat, Kandahar, Kabul and Bagram
	TB cases (all forms) notified from this intervention	322					
	All TB cases notified in this CTB area (denominator)	4,188					
	% of cases notified from this intervention	7.7%					
Reported by Urban DOTS	CTB geographic focus for this intervention	4 cities					Urban DOTS contributions to TB case findings in 4 cities of Jalalabad, Herat, Kandahar and Kabul
	TB cases (all forms) notified from this intervention	2,155					
	All TB cases notified in this CTB area (denominator)	3,768					
	% of cases notified from this intervention	57%					
Children (0-14)	CTB geographic focus for this intervention	15 provinces					
	TB cases (all forms) notified from this intervention	1,154					
	All TB cases notified in this CTB area (denominator)	6,845					
	% of cases notified from this intervention	16.8%					
Reported by prisons	CTB geographic focus for this intervention	5 cities					There are five prisons covered by Urban DOTS in Jalalabad, Herat, Kandahar, Kabul and Bagram
	TB cases (all forms) notified from this intervention	52					
	All TB cases notified in this CTB area (denominator)	4,188					
	% of cases notified from this intervention	1.3%					

6. Challenge TB-supported international visits (technical and management-related trips)

#	Partner	Name of consultant	Planned quarter				Specific mission objectives	Status (cancelled, pending, completed)	Dates completed	Duration of visit (# of days)	Additional Remarks (Optional)
			Q1	Q2	Q3	Q 4					
1	MSH	Paultre Desrosiers					Develop the SOP for extrapulmonary TB case notification and management	Pending		21 days	Consultant changed, originally Gloria Sanigwa
2	MSH	Pedro Suarez					Monitor overall project management	Pending		15 days	The first STTA will occur in April 2016
3	MSH	Pedro Suarez					Monitor overall project management	Pending		15 days	his STTA will happen in Aug 2016
4	MSH	Gloria Sanigwa					Develop SOP for TB and diabetes and other comorbidity and program management	Pending		15 days	Planned for April 2016
Total number of visits conducted (cumulative for fiscal year)								0			
Total number of visits planned in approved work plan								4			
Percent of planned international consultant visits conducted								0%			

7. Quarterly Indicator Reporting

Sub-objective:	1. Enabling Environment					
Performance indicator	**Disaggregated by**	**Frequency of collection**	**Baseline (timeframe)**	**End of year target**	**Results to date**	**Comments**
1.1.1. % of notified TB cases, all forms, contributed by non-NTP providers (i.e. private/non-governmental facilities)	CTB intervention area	Quarterly	10% (500) 2014	15% (800)	200 (3%)	The community based DOTS started late in October 2015. Thus, the target has not been achieved. CTB enhanced implementation and will compensate this deficit in the upcoming quarters. As this CB-DOTS, contribution by only CHWs (no private sector)
1.1.12. AFGHANISTAN SPECIFIC: #/% of bacteriologically confirmed TB cases referred by community and community health workers	Gender, geographical location	Quarterly	18% (1,452) from CB-DOTS approach (2014)	20% (1,613 from CB-DOTS approach)	200 (3%)	See above

Sub-objective:	3. Patient-centered care and treatment					
Performance indicator	**Disaggregated by**	**Frequency of collection**	**Baseline (timeframe)**	**End of year target**	**Results to date**	**Comments**
3.1.3. Case notification rate	Gender, age category, geographical location	Quarterly	68% (2015)	73%	(69%) 157/100,000 population	
3.1.5. #/% health facilities implementing intensified case finding (i.e. using SOPs)	National	Annually	704 (2015)	754	738 (98%)	National
3.1.8. % of TB cases (all forms) diagnosed among children (aged 0-14)	Geographical location	Quarterly			1,154 (17%)	
3.1.15. #/% of TB cases (all forms) diagnosed via Urban DOTS or other urban TB approaches	Geographical location	Quarterly	5007 (2014)	9500	2155 (31%)	Mazar was excluded because urban-DOTS started late

Sub-objective:	3. Patient-centered care and treatment					
Performance indicator	**Disaggregated by**	**Frequency of collection**	**Baseline (timeframe)**	**End of year target**	**Results to date**	**Comments**
3.1.17. AFGHANISTAN SPECIFIC: # of household contacts of bacteriologically confirmed TB cases (Index cases) screened for TB in Kabul	Geographical location	Quarterly	1000 (2015)	2600	800	This is an estimation
3.1.14. #/% of total cases notified that were referred or diagnosed via CB approaches	15 provinces	Quarterly	1452/16% (2015)	1613 (20%)	200 (3%)	
3.2.22. #/% of TB patients followed by community-based workers/volunteers during at least the intensive phase of treatment	CTB intervention process (15 provinces)	Quarterly	18% (1452) from CB-DOTS approach (2015)	20% (1613) from CB-DOTS approach	260	
3.2.1. Number and percent of TB cases successfully treated (all forms) by setting (i.e. private sector, pharmacies, prisons, etc.) and/or by population (i.e. gender, children, miners, urban slums, etc.).	Five provinces: Kabul, Herat, Mazar, Jalalabad and Kandahar	Quarterly	69% for CTB cities (Cohort 2013)	72%	244/332 (74%)	
3.2.2. Treatment success rate for pediatric TB patients	Kabul	Quarterly		NA		The data is not collected through NTP surveillance system (the data is aggregated)
3.2.15. #/% of prisons providing DOTS	Geographical location	Quarterly	2 (2015)	6	4	
3.1.1. Number and percent of cases notified by setting (i.e. private sector, pharmacies, prisons, etc.) and/or population (i.e. gender, children, miners, urban	CTB intervention process: urban DOTSs and CB-DOTS)	Quarterly	9,952 (2015) (8,500 in CTB cities + 1,452 from CB-DOTS)	11,013 (9,400 in CTB cities + 1,613 from CB-DOTS)	2,155 (performance of Urban DOS in 5 provinces)	Urban-DOTS has been initiated in four cities between August and September 2015. It was initiated in Mazar city in late November 2015

Sub-objective:	3. Patient-centered care and treatment					
Performance indicator	**Disaggregated by**	**Frequency of collection**	**Baseline (timeframe)**	**End of year target**	**Results to date**	**Comments**
slums, etc.) and/or case finding approach						
3.1.4. Number of MDR-TB cases detected	National (CTB does not cover this area)	Quarterly	31 (2014)		80	In total, 80 MDR-TB cases were notified by the NTP throughout Afghanistan
3.2.7. Number and percent of MDR-TB cases successfully treated	National(No CTB investment)	annually	67% (cohort 2011)			
3.2.20. #/% of health facilities providing CB-DOTS services	geography	quarterly	450 (2014)	500	223	The rests of the facilities will be covered next quarter
3.1.1. Number and percent of cases notified by setting (i.e. private sector, pharmacies, prisons, etc.) and/or population (i.e. gender, children, miners, urban slums, etc.) and/or case finding approach	CTB intervention process: urban DOTSs and CB-DOTS)	quarterly	9,952 (2015) (8,500 in CTB cities + 1,452 from CB-DOTS)	11,013 (9,400 in CTB cities + 1,613 from CB-DOTS)	2,155	

Sub-objective:	5. Infection control					
Performance indicator	**Disaggregated by**	**Frequency of collection**	**Baseline (timeframe)**	**End of year target**	**Results to date**	**Comments**
5.1.1. Status of TB IC implementation in health facilities	Geographical location	quarterly	2 (2015)	3	2	
5.1.2. #/% of health facilities implementing TB IC measures with Challenge TB support (stratified by TB and PMDT services)	Geographical location	quarterly	160 (2014)	190	170	

Sub-objective:	5. Infection control					
Performance indicator	**Disaggregated by**	**Frequency of collection**	**Baseline (timeframe)**	**End of year target**	**Results to date**	**Comments**
5.1.5. #/% of high-risk sites in which TB IC is implemented with Challenge TB support (stratified by applicable sites: PMDT, HIV, mines, prisons, etc.)	Geographical location	Quarterly	40 (2015)	30	10	10 additional health facilities covered by TBIC this quarter
5.1.7. Community-based TB IC has been incorporated into national guidance	Geographical location	Annually	Yes (2015)	Yes	Yes	
5.2.2. #/% of HCWs screened (frequency of measurement based on policy)	Cadre	Annually	240 (2011)	600		Planned for next quarter
5.2.3. Number and % of health care workers diagnosed with TB during reporting period		Annually	7 (2011)	15		Planned for next quarter

Sub-objective:	7. Political commitment and leadership					
Performance indicator	**Disaggregated by**	**Frequency of collection**	**Baseline (timeframe)**	**End of year target**	**Results to date**	**Comments**
7.2.1. % of NTP budget financed by domestic resources	Geographical location	Annually	8% government spending in TB (global TB report 2014)	9%		CTB will do this exercise at the end of Year 2
7.2.3. % of activity budget covered by private sector cost share, by specific activity	Geographical location	Annually	N/A	1% of total CTB project	0.1%	USD 3,700 contributed this quarter as 37 private hospital provided DOTS and allocated one room with estimated cost of USD 100 per month
7.3.1. NTP leadership and management competency score (TBD)	Geographical location	Quarterly	N/A	30% improvement from baseline		The NTP core function tool was developed and shared with the NTP. The tool will be implemented in the next Q2

Sub-objective:	10. Quality data, surveillance and M&E					
Performance indicator	**Disaggregated by**	**Frequency of collection**	**Baseline (timeframe)**	**End of year target**	**Results to date**	**Comments**
10.1.2. #/% of eligible health facilities reporting TB data in real time or at least quarterly via the ERR	Geographical location	Quarterly	555/79%	680/100%	555/82%	
10.1.4. Status of electronic recording and reporting system	National	Annually	1 (2015)	1	1	
10.1.9. AFGHANISTAN SPECIFIC: #/% of health facilities using new TB recording and reporting forms	Geographical location		0 (2015)	680/100%		The NTP has not started using new definitions
10.2.1. Standards and benchmarks to certify surveillance systems and vital registration for direct measurement of TB burden have been implemented	National	Annually	Yes (2014)	Yes		Planned for next quarter
10.2.4. #/% of operations research, evaluation or epidemiological assessment study results disseminated (stratified by level of dissemination: report, presentation, publication)	National	Annually	4 (2014)	6	1	The results of the TB and diabetes study was shared with the NTP and will be presented at the TB results conference next quarter
10.2.6. % of operations research project funding provided to local partner (provide % for each OR project)	Geographical	Annually	20%(2015)	50%		Planned for Quarter 2
10.2.7. Operational research findings are used	National	Annually	Yes (2014)	Yes		

Sub-objective:	10. Quality data, surveillance and M&E					
Performance indicator	**Disaggregated by**	**Frequency of collection**	**Baseline (timeframe)**	**End of year target**	**Results to date**	**Comments**
to change policy or practices (ex, change guidelines or implementation approach)						
11.1.3. # of healthcare workers trained, by gender and technical area	Gender, Cadre	quarterly	510 (2015)	740	279 (male 237, female 42)	39 lab technician, 240 doctors, nurses
11.1.5. % of USAID TB funding directed to local partners	geography	annually	3,670 (2015)	12500	USD 6,691	The cost of subcontract with CB-DOTS for the period Oct-Dec 2015

Sub-objective:						
Performance indicator	**Disaggregated by**	**Frequency of collection**	**Baseline (timeframe)**	**End of year target**	**Results to date**	**Comments**
2.1.2. A current national TB laboratory operational plan exists and is used to prioritize, plan and implement interventions.	National: CTB does not invest in this area	Annually	1 (August 2015)			
2.2.6. Number and percent of TB reference laboratories (national and intermediate) within the country implementing a TB-specific quality improvement program i.e. Laboratory Quality Management System (LQMS).	National(CTB does not invest in this area)	Annually	0%(0/2) (2014)			
2.2.7. Number of GLI-approved TB microscopy network standards met	National(CTB does not invest in this area)	Annually	NA			
2.3.1. Percent of bacteriologically confirmed TB cases who are tested for drug resistance with a recorded result.	Geography	Quarterly	7% of all estimated MDR-TB cases (2014)			
6.1.11. Number of children under the age of 5 years who initiate IPT	National, CTB intervention area	quarterly	1038 (2015)	2500	**1846**	
6.1.2. % of eligible persons completing LTBI treatment, by key population and adherence strategy	National, CTB intervention area (measuring for children only)	quarterly	1038(100%) (2015)	2500 (100%)	**1,440**	
8.1.3. Status of National Stop TB Partnership	geography	Quarterly	2 (2015)	3 end of Y2	**2**	
8.1.4. % of local partners' operating budget covered by diverse non-USG funding sources	National	Annually	0% (2014)	TBD		

8.2.1. Global Fund grant rating	National	Quarterly	B1 (2010-2015)		**B1 2015**	
9.1.1. Number of stock outs of anti-TB drugs, by type (first and second line) and level (ex, national, provincial, district)	geography, national (CTB does not address this area)	annually	0 (2015)			

Billboard with TB message installed in Ali Sher district, Khost province


Community health workers' orientation session at Ali Sher health facility, Khost province